FH
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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION

MPA/155374

PRELIMINARY RECITALS

Pursuant to a petition filed February 08, 2014, under Wis. Stat. §49.45(5), and Wis. Admin. Code §HA 3.03(1), to review a decision by the Office of the Inspector General (OIG) in regard to Medical Assistance (MA), a telephonic hearing was held on March 20, 2014.

The issue for determination is whether the OIG correctly modified petitioner's prior authorization (PA) request for physical therapy (PT).

There appeared at that time and place the following persons:

PARTIES IN INTEREST:
Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, Wisconsin 53703
By: written submittal of: Dr. Pamela Hoffman
Division of Health Care Access and Accountability
1 West Wilson Street, Room 272
P.O. Box 309
Madison, WI 53707-0309

ADMINISTRATIVE LAW JUDGE:
Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [redacted]) is a resident of Sheboygan County. She is MA-eligible.
2. Petitioner is 5 years old and lives at home with her family. She is diagnosed with Osteogenesis Imperfecta (OI).
3. On December 16, 2013 the petitioner's private PT provider, Rehab Resources, submitted a PA request (PA# [redacted]) for petitioner to receive private PT once per week for 26 weeks.
4. On January 13, 2014 the OIG issued a notice to petitioner indicating that it was modifying the PA request to 6 sessions because it did not find the level of PT requested to be medically necessary.

DISCUSSION

Physical Therapy (PT) is covered by MA under Wis. Admin. Code, §DHS 107.16. Generally it is covered without need for prior authorization (PA) for 35 treatment days per spell of illness. Wis. Admin. Code, §DHS 107.16(2)(b). After that, PA for additional treatment is necessary. If PA is requested, it is the provider's responsibility to justify the need for the service. Wis. Admin. Code, §DHS 107.02(3)(d)6.

In determining whether to grant prior authorization for services or equipment, the OIG must follow the general guidelines in §DHS 107.02(3)(e). That subsection provides that the OIG, in reviewing prior authorization requests, must consider the following factors:

1. The medical necessity of the service;
2. The appropriateness of the service;
3. The cost of the service;
4. The frequency of furnishing the service;
5. The quality and timeliness of the service;
6. The extent to which less expensive alternative services are available;
7. The effective and appropriate use of available services;
8. The misutilization practices of providers and recipients;
9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines;
10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
12. The professional acceptability of unproven or experimental care, as determined by consultants to the department.

The key factor of the 12 listed above is "medical necessity", which is defined in the administrative code as any MA service under chapter DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Wis. Adm. Code, §DHS 101.03(96m).

"Medically necessary" is therefore more of a *legal* term as opposed to a *medical* term. Therefore, while a medical professional or provider may conclude an item is "medically necessary", it is the OIG which must adjudicate the request and determine whether the item or service for which payment is sought meets the legal definition of "medically necessary." In prior authorization cases the burden is on the person requesting the PA to demonstrate the medical need for the services. Wis. Admin. Code §DHS 107.02(3)(d)6; see also, Wis. Admin. Code §DHS 106.02(9)(e)1.

As an MA-certified provider, providers who request the MA program to reimburse for their services are required, by law, to completely and accurately complete the prior authorizations which they submit. Not every medical provider can submit a PA to the MA program to request reimbursement. Only those providers who have been certified to provide MA-reimbursable services are allowed to submit a PA. One of the reasons these medical providers are "certified" is to assure they are kept up to date on changes in the MA program and the prior authorization process. MA-certified providers are expected to know the rules and policies controlling the prior authorization process and the completion of the prior authorization forms.

In this case the OIG modified the PA request because it determined that the level of PT requested was not medically necessary. Essentially the OIG is stating that the petitioner's provider has not justified that the requested direct out-patient PT 1 time weekly for 26 weeks is needed to prevent fractures. The OIG modified the PA because it determined that the private PT is not cost-effective compared to alternative medically necessary services which are reasonably accessible to the petitioner – such as her PT at school and her home exercise program (HEP). Essentially the OIG is stating that the school PT and the family provide interventions to prevent, identify and treat her disability, and maintain her skills through routine and repetitive participation in a HEP. The OIG did allow 6 visits for the provider to help manage petitioner's movement activities and endurance through a HEP with her family.

Petitioner's mother and private PT provider testified at hearing regarding petitioner's PA request. They were not able to show that the PT requested would reduce petitioner's fractures or that neuromuscular interventions were medically necessary for her impairments. The information shows that fractures may occur for any reason with OI and that petitioner has some strength and endurance deficits, which is understandable after a fracture/immobilization occurs. But strength and endurance deficits do not support a need for twice weekly PT. I certainly understand that more PT is better in a mother's eyes, however, it is not the same as meeting the MA rules for justifying the service. This is not to diminish the challenges petitioner faces and I do not doubt that petitioner benefits from the PT; however, under the documentation I have, it does not support the level of therapy requested. I agree with the OIG that the modification of PT visits to provide interventions and/or modify tasks or environment accordingly through the HEP appears the most appropriate course under these MA rules with the documentation provided. The private PT

provider can always submit a new or amended PA if the allowed visits are not sufficient and has the documentation to support the request.

I add, assuming petitioner finds this decision unfair, that it is the long-standing position of the Division of Hearings & Appeals that the Division's hearing examiners lack the authority to render a decision on equitable arguments. See, Wisconsin Socialist Workers 1976 Campaign Committee v. McCann, 433 F.Supp. 540, 545 (E.D. Wis.1977). This office must limit its review to the law as set forth in statutes, federal regulations, and administrative code provisions.

CONCLUSIONS OF LAW

The OIG correctly modified petitioner's PA request for PT.

THEREFORE, it is ORDERED

That the petition for review herein be dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson

Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee, Wisconsin, this 13th day of May, 2014

\sKelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on May 13, 2014.

Division of Health Care Access and Accountability